STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155779	A. BUILDING _____ B. WING _____	C 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	**9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the investigation of Complaints IN00140516, IN00140936, IN00141502, and IN00142308.

This visit was in conjunction with a Post Survey Revisit (PSR) to the investigation of Complaints IN00136857 and IN00136889 completed on 10/10/13.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure survey completed on 11/21/13. This visit included the PSR to the investigation of Complaint IN00138950 completed on 11/21/13.

Complaint IN00140516: Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00140936: Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00141502: Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00142308: Substantiated. No deficiencies related to the allegations are cited.

Survey dates: January 8, 9, 10, and 13, 2014

Facility number: 012305
Provider number: 155779
AIM number: 200987990

Survey Team:
Janet Stanton, R.N.--Team Coordinator
Michelle Hosteter, R.N.
Sandra Nolder, R.N.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155779	A. BUILDING _____ B. WING _____	C 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HEALTH CAMPUS	**9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Gloria Bond, R.N. (1/9 and 10) Census bed type: SNF--42 SNF/NF--6 Residential--52 Total--100 Census payor type: Medicare--13 Medicaid--6 Other--81 Total--100 Residential Sample: 6 Prairie Lakes Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B, and 410 IAC 16.2 in regard to the investigation of Complaints IN00140516, IN00140936, IN00141502, and IN00142308. Quality Review was completed by Tammy Alley on January 15, 2014.	F 000		